POLICY DELIVERY RECEIPT

(NAME AND ADDRESS OF INSURANCE COMPANY MUST BE INSERTED BEFORE THIS FORM IS USED)

This receipt must be signed by the Insured at the time of policy delivery and returned to the company listed at the address above.

Named Insured: _____

Policy Number: _____

Date of Delivery: _____

I understand that I have 30 days to review my Policy and that the 30 days begins on the Date of Delivery.

The signatures below affirm that the above referenced policy has been delivered and received by the insured.

Signature of Named Insured

Producer Name (Please Print)

Signature of Producer	National Producer Number (if applicable)